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Child Death and Serious Case Review Processes in the UK

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Introduction

The University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection (CLiCP) is a research centre based within the School of Education at the University of Edinburgh. It conducts research and provides analysis and commentary on child protection policy across the UK: in each jurisdiction and UK-wide.

A major focus of CLiCPs work involves the tracking and analysis of the content and direction of child protection policy and developments across the UK. We intend to build incrementally towards a general overview of child protection in the UK over a two year period (2008-2010) by producing a series of papers, each based on analysis of a key aspect of child protection.

This paper considers child death and Serious Case Review (SCR) processes across the UK. Finding out what happened when a child dies is a basic human right now enshrined in the Human Rights Act 1998. Processes of review are, therefore, crucial. England, Wales, Scotland and Northern Ireland do not have the same processes and it is important to consider the differences. This paper outlines, compares and contrasts the processes which have existed since 1989 in England and Wales, 2003 in Northern Ireland and 2007 in Scotland to review serious cases. In addition to processes for reviewing serious cases some areas of the UK have more recently introduced, or are planning to introduce, wider processes for review of all child deaths, or all unexpected deaths and the paper also sets out these new developments. Lastly it considers the effectiveness of both serious case review processes and wider child death review processes.

Processes for reviewing deaths from child abuse and neglect

Background

Systems for reviewing child deaths from abuse or neglect were introduced so that we might learn from these cases. Review processes in England, Wales and Northern Ireland are well established; processes were introduced more recently in Scotland.

Serious Case Review (SCR) - England and Wales

England and Wales both have a system known

as SCR for reviewing deaths from child abuse or neglect. A system of SCR known as Part 8 review was introduced in England and Wales in 1991, with guidance provided to Area Child Protection Committees (ACPCs) in Chapter 8 of Working Together Under the Children Act 1989 (Department of Health 1991). ACPCs were required to carry out a case review when a child died and abuse or neglect was known, or suspected, to be a factor in the death. The purpose of case review was to establish



whether there were lessons which could be learned from the case in terms of improving inter agency working and better safeguarding children. The guidelines for conducting case reviews were revised in England in the 1999 version of *Working Together to Safeguard Children* when the term 'serious case review' was first introduced and in 2000 in Wales when the National Assembly produced its own version of *Working Together to Protect Children*.

The Children Act 2004 and its accompanying regulations put SCRs on a statutory footing in England and Wales. Local Safeguarding Children Boards (LSCBs) replaced ACPCs in the 2004 Act and it is now mandatory for LSCBs to conduct a SCR if a child dies and abuse or neglect is suspected to be a factor in the death. Whereas ACPCs were responsible for *monitoring* the process of case review SCR has now become a *function* of LSCBs (Brandon et al 2008; Rose and Barnes 2008). The basic framework for the conduct of reviews is essentially the same but the criteria for determining when a SCR should be undertaken are broader. Chapter 8 of *Working Together to Safeguard Children* (HM Government 2006) and *Safeguarding Children: Working together under the Children Act 2004* (Welsh Assembly Government 2006) state that a SCR should now be considered in other circumstances: where a child sustains life threatening injury or serious impairment of health and development through abuse or neglect; where they have been subjected to particularly serious sexual abuse; where a child has been killed by a parent with a mental illness; where the death is a child suicide; where the case gives rise to concerns about inter agency working to protect children from harm; and in England where a parent has been murdered and a homicide review is being initiated. Pre 2004 SCRs typically focused on deaths from severe physical assault or extreme neglect but there is some suggestion that more recently a broader approach has been taken to include suicide, deaths related to domestic violence incidents and other deaths related to, but not directly caused by, maltreatment suggesting that LSCBs in England are taking the new criteria seriously (Brandon 2008; Rose and Barnes 2008).

Working Together to Safeguard Children (HM

Government 2006) states that the SCR Panel should involve at least LA children's social care, health, education and the police. The Welsh guidance (Welsh Assembly Government 2006) does not specify membership of the review panel.

A further change since 2004 is that an independent author for the overview report is now a requirement. Interestingly, however, in a recent evaluation of 50 case reviews Ofsted (2008) found no correlation between the quality of the overview report and the independence of its author; some of the best reports were written by authors employed by the local authority.

In England since 1st April 2008 copies of the overview report are sent to the Office for Standards in Education (OFSTED) rather than the Commission for Social Care Inspection (CSCI). Ofsted now have authority to evaluate SCRs, covered by Section 20 of the Children Act 2004. They assess the extent to which the review fulfilled its purpose by reviewing the involvement of agencies, the rigour of analysis and the capacity for ensuring that the lessons identified are learned. LSCBs must provide a complete set of papers for evaluation including terms of reference, overview report, individual management reports, recommendations and action plan. Inspectors evaluate the review against a set of grade descriptors and in accordance with an evaluation template. A report on 50 evaluations carried out between 1 April 2007 and 31 March 2008 was published in December 2008 (Ofsted 2008). In Wales copies of reports have to be given to the Welsh Assembly Government but evaluation of case reviews is not undertaken.

Sinclair and Bullock (2002) were critical of the fact that families were excluded from the case review process in England. The latest edition of *Working Together* (HM Government 2006) has addressed this by requiring agencies to consider not just whether, but how, family members should be involved. The Welsh Guidance (Welsh Assembly Government 2006) also states that the review panel should consider how family members can contribute to the review and who should be responsible for facilitating families' involvement. In their

analysis of SCRs in England Rose and Barnes (2008) found evidence of family members contributing in a fifth of cases. They stated, however, that this may not be the full picture since family members may have declined an invitation to contribute, the circumstances of the case may have made it inappropriate, or the report may not have recorded discussions or negotiations about this issue. Families were involved in nine out of 47 cases which Brandon et al (2008) studied in depth; in a small number of cases the child also contributed. Ofsted (2008) found little evidence of working with families: eight out of 50 case reviews recorded that families made a contribution; a further 8 noted that families were invited to contribute but declined; in 19 case reviews the issue was not covered at all; in 11 there was a statement that family members were not involved; a positive decision not to involve family members was noted in 3. Ofsted commented that it was not clear how much effort went into seeking families' participation.

The requirement to involve family members is a major development which requires appropriate facilitation, planning and resources and Rose and Barnes (2008) stress that family members' expectations about the process need to be considered since they may expect the SCR to be more like an inquiry. Involvement of family members also raises issues in terms of what they are prepared to have recorded and considered as part of the review since they may understandably be reluctant to contribute information which could cast themselves or other family members in a negative light.

Both the English and Welsh guidance (HM Government 2006; Welsh Assembly Government 2006) include some guidelines on the format of the review report but only to the extent that it should have an introduction (setting out the circumstances leading to the review, terms of reference and contributors); should cover the facts (by use of a genogram, chronology of involvement with the family and an overview); have an analysis section (stating why events occurred, what decisions were made and actions taken); and a conclusions and recommendations section (stating what lessons can be drawn both nationally and locally; recommendations should be few in

number, focused, specific and capable of implementation). Rose and Barnes (2008) found that review reports varied in length, style and presentation in England:

- Half the reports they analysed were under 30 pages long but a fifth more than 75 pages;
- There was variation in the use of genograms; some reports omitted a genogram altogether;
- A quarter highlighted lessons for national policy and practice in addition to local lessons
- Recommendations were generally relatively few in number (up to 20), focused, specific and capable of implementation; however, in 12 reviews there were up to 40 recommendations, one had 40 to 60 and one had 80.

Brandon et al (2008) found that summaries focused narrowly on recommendations and procedures. They recommended greater consistency in the format and structure of summaries.

The English guidance states that reviews should be completed within four months of the LSCB chair's decision to initiate a review. The Welsh guidance states that a review should normally be completed within six months. 12% of English reviews analysed by Rose and Barnes (2008) were completed within the timescales laid down or nearly so; a further third were completed within 12 months of the incident; 17% were not dated; 45% took over a year to complete. Ofsted (2008) judged a large proportion of case reviews as inadequate due to timescales. It was not uncommon for SCRs to take more than a year to complete and some took as long as three years.

The DfES review of LSCBs (2006) found there was substantial variation over how LSCBs in England handled SCRs. They were not always confident about their capacity to conduct reviews which were very resource intensive. In some cases reviews were only undertaken after a long delay and some took a long time to complete. The Third Joint Inspectors' Report into Safeguarding Children in England (Ofsted 2008a) also pointed to serious delays in the

production of SCRs in most cases. A quarter of LSCBs did not file any SCRs from April 2006 to October 2007. Local variations in the number of SCRs were not fully explained by the number of deaths in each area. The report concluded that LSCBs were interpreting the guidance inconsistently and some were not giving priority to SCRs.

A Welsh review (Local Safeguarding Children Boards, Wales, Review of Regulations and Guidance 2008) similarly found that the costs of undertaking SCRs were an increasing burden on LSCBs. The Review team acknowledged that it was difficult for LSCBs to factor such costs into a funding model since not all LSCBs will be faced with these costs on a regular basis. Furthermore the costs of reviews will vary, depending on the complexity of the case and, in some cases, the need to appoint an independent person to prepare the overview report. They recommended that further work should be undertaken into the costs and funding of SCRs and that a sustainable model for undertaking and funding future SCRs be devised.

Case management review - Northern Ireland

Since 2003 ACPCs in Northern Ireland have had responsibility to undertake case management reviews (similar to SCRs in England and Wales) where a child dies, including death by suicide, and abuse or neglect is known, or suspected, to be a factor in the child's death. They should also consider undertaking a case management review where a child has sustained a potentially life threatening injury through abuse (including sexual abuse) or neglect; has sustained serious and permanent impairment of health or development through abuse or neglect; or the case gives rise to concerns about the way in which local professionals and services worked together to safeguard children. The purpose of a case management review is to establish whether there are lessons to be learned from the case and to improve inter agency working and thus provide better safeguards for children. Chapter 10 of Co-operating to Safeguard Children (Department of Health, Social Services and Public Safety 2003) provides guidance on when and how a case management review should be undertaken. The circumstances

under which a review should take place are similar to those in England and Wales but the Northern Ireland guidance does not specifically state that a case management review should be undertaken where a parent has been murdered and a homicide review is being initiated, or where a child has been killed by a parent with a mental illness.

Unlike guidance in the rest of the UK the Northern Ireland guidance says little about the involvement of families in the review process apart from that the ACPC chair should consider whether family members should be invited to contribute to the review.

As in England the guidance states that the Case Management Review Panel should include as a minimum social services, health, education and the police. Reviews should normally be completed within five months. The guidelines setting out the format of the report are almost identical to those in the Welsh guidance. ACPCs have to send copies of the report to the Department of Health, Social Services and Public Safety.

Significant case review – Scotland

While ACPCs/LSCBs in England, Wales and Northern Ireland have undertaken case reviews when a child dies and abuse or neglect is known, or suspected, to be a factor in the child's death for many years, there was, until recently, no equivalent procedure in Scotland. In 2007 Interim Guidance for Child Protection Committees (CPCs) for Conducting a Significant Case Review (similar to SCRs in England and Wales and case management reviews in Northern Ireland) was published (Scottish Executive 2007).

Prior to 2007 there was no single system of notification, no agreed criteria for inclusion and no national system of review. Some local areas, usually through CPCs, did undertake reviews of professional practice following deaths of children known to agencies and where there were concerns about abuse or neglect reviews of significant cases were sometimes undertaken by agencies involved in child protection, whether singly or jointly. There was, however, no standard approach to when and how such reviews were undertaken. Local

areas and individual agencies had their own processes and procedures in place and across Scotland there was a degree of inconsistency in how decisions were made on when to call for a review; what type of review to hold; the management of the process; the skills and expertise required to undertake the review; the reporting requirements of the review; and the implementation of the review's findings (Axford and Bullock 2005). As a result 'It's everyone's job to make sure I'm alright' (Scottish Executive 2002), the report of the national audit and review of child protection in Scotland, recommended the need for guidance on how reviews of child fatalities should be conducted. A Child Death and Significant Case Review Group was established as part of the Child Protection Reform Programme and extensive consultation took place during 2006 on draft guidance for conducting significant incident reviews. A study of international comparisons of child death review processes was commissioned to inform the review group (Axford and Bullock 2005).

The interim guidance (Scottish Executive 2007) provides more clarity and consistency on what should be done and how best to act on the lessons learnt from a Significant Case Review, both locally and across Scotland. It states that a significant case review should be undertaken when a child dies and abuse or neglect is known or suspected to be a factor in the child's death; the child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR; the death is by suicide or accidental death; the death is by alleged murder, culpable homicide, reckless conduct, or act of violence; the child was looked after by the local authority; when a child has not died but has sustained significant harm or risk of significant harm, under one or more of the categories of abuse and neglect set out in *Protecting Children – A Shared Responsibility: Guidance for Inter-Agency Co-operation* (Scottish Office 1998); if the incident or accumulation of incidents gives rise to serious concerns about professional and/or service involvement or lack of involvement. The grounds for undertaking a significant case review are similar to those for undertaking a SCR in England and Wales but do not include where a parent has been murdered and a

homicide review is being initiated. Neither does the guidance specifically state that a case review should be undertaken where a child has been killed by a parent with a mental illness though this is presumably covered by death by alleged murder or culpable homicide. The outcomes of the review are stated as: to identify whether inter-agency working can be improved to better protect children; and to contribute to the development and sustainability of robust quality assurance procedures and continuous improvement.

There is a section in the guidance on the involvement of family/carers which states that the family/carers of the child involved should be kept informed at various stages of the review. It suggests that it may be useful to assign a member of staff to be a liaison point for the family and their role could include making arrangements to interview the child, family/carers or significant adults involved. There is also a section on supporting staff through the review process which is not found in the guidance in the other parts of the UK.

The guidance does not specify which agencies should be involved in the review but a section on identifying the review team sets out the skills and competencies required of the lead reviewer and review team. Timescales for completion of a case review are not given but the guidance states that for every case the CPC should agree a deadline for when reports should be produced in the light of the circumstances and context of that particular case. It states, however, that there is an assumption that the CPC will proceed as speedily as is feasible through the various processes of review.

The guidance states that there should be a degree of consistency in the structure and content of reports and sets out the sections that should be covered: introduction (summarising the circumstances that led to the review, the remit and list of contributors); a chronology of agency/professional involvement; the extent of family/carers' involvement; a list showing each occasion of contact with the child or family and outlining whether the child's views and wishes were

sought and if they were expressed; analysis; conclusions; and recommendations (which should be few in number, focused, specific and capable of being implemented). Scotland is the only area of the UK to state that the extent of family/carers' involvement should be documented as well as whether the child's views and wishes were sought and expressed. After publishing the report of a significant case review the guidance states that CPCs should provide briefings for the government and inspectorates as well as providing annual analysis of all cases referred for a significant case review to the government. However, while CPCs send information about significant case reviews to the Social Work Services Inspectorate (SWIA), the government only receive information via CPC's Annual Reports.

Processes for reviewing deaths from child abuse and neglect: summary

- All parts of the UK have similar processes for reviewing deaths from child abuse and neglect
- A system of SCR known as Part 8 review was introduced in England and Wales in 1991
- The Children Act 2004 and its accompanying regulations put SCRs on a statutory footing in England and Wales
- Since 2003 ACPCs in Northern Ireland have had responsibility to undertake case management reviews
- Scotland introduced Interim Guidance for Child Protection Committees (CPCs) for Conducting a Significant Case Review in 2007; prior to 2007 there was no national system of review in Scotland.

New processes for wider review of child deaths

Background

As well as processes for reviewing deaths from child abuse and neglect some parts of the UK have recently introduced, or plan to introduce processes for wider review of child deaths similar to those which exist in other countries. Here we examine these new developments for wider review of child deaths in England, Wales and Northern Ireland. At the time of writing (February 2009) the Scottish Government has not announced any plans to introduce processes for review of all deaths or rapid

response to all unexpected deaths. Most of the evidence in this section comes from England where systems for wider review of child deaths are further advanced than in Wales and Northern Ireland. New processes for review of child deaths are being introduced so that we can learn from individual deaths and use this information, both locally and nationally, to hopefully prevent future deaths, or in the case of expected deaths, to learn how we can better care for children and their families in the period leading up to the death.

Countries such as the US, Canada and Australia have had child death review processes for some years. Child fatality review teams were first developed in the US because of concerns about the underreporting of child abuse deaths. The first documented multi agency and systematic response to child deaths appears to have been initiated in 1978 by Los Angeles County. Since 1978 child death review processes have spread across the US and by 2007 all but one state had established a child death review team (Bunting and Reid 2005; Axford and Bullock 2005).

Until recently the UK had processes for reviewing deaths from child abuse and neglect, as outlined above, but no parts of the UK had wider child death review processes equivalent to those in the US and some Canadian and Australian states. There have, however, always been health based approaches to infant and child mortality review in the UK and there is a long established history of hospital mortality reviews. Hospitals regularly carry out audits or internal reviews of some, but not all, child deaths. These health based approaches to reviewing child deaths are not considered in this paper.

England

As well as having a statutory responsibility to undertake SCRs, since 1st April 2008, LSCBs in England have two new interrelated responsibilities in relation to review of child deaths:

- They have a duty to review all child deaths from 0 to 18 in a systematic way through a Child Death Overview Panel (CDOP);
- They have a duty to respond rapidly to individual unexpected deaths of all

children, not just those in contact with organisations responsible for safeguarding their welfare, in the local authority area, through a rapid response team (RRT).

LSCBs also have a statutory responsibility to use the aggregated findings from all child deaths, collected according to a nationally agreed data set, to inform local strategic planning on how best to safeguard and promote the welfare of children in their area. An unexpected death is defined as a death 'which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death' (HM Government 2006). The overall purpose of these new child death review processes is to understand why children die and put in place interventions to protect other children and prevent future deaths.

Chapter 7 of *Working Together to Safeguard Children* (HM Government 2006) sets out the new process for reviewing child deaths setting the scene for England to become the first country in the world to have national standards and procedures for the investigation and management of unexpected child deaths and for reviewing all deaths (Sidebotham et al 2008). The guidelines in *Working Together* were based on the findings of the Kennedy Report into the management of SUDI (RCPATH and RCPCH 2004) which was convened after three high profile infant death prosecutions failed. The government announced it would set up these new processes in its response to the Inquiry into the death of Victoria Climbié. Prior to these new processes it was likely that only a minority of child deaths received a post mortem and an even smaller number were accorded a public inquest but this information is not actually known since a breakdown of figures is not available by age from the Registrar General's Office. Figures are available for Northern Ireland where only 20% of child deaths receive a post mortem and just 13% are subject to a public inquest (Bunting and Reid 2005).

Sidebotham et al (2008) undertook an evaluation of nine pilot sites across England where child death review teams were being established. 60 out of 144 (42%) of LSCB chairs

responded to an initial questionnaire in October 2006: 84% had developed or were in the process of developing a rapid response protocol (although a proportion of these only related to infant deaths rather than all unexpected child deaths); only three boards had established a CDOP with a further 36 (60%) in the process of establishing one. The results suggested a significant gap at that stage in progress towards achieving the requirement for child death review laid out in *Working Together*. Nine of the LSCBs who responded to the initial questionnaire were selected as sites for further research. None of the nine overview panels had managed to set up a foolproof system of notification. One panel had developed a simple notification form which has since been used as a basis for developing a national notification form. Most sites commented that current systems for notification of deaths were inadequate. They reported that they had to rely on a combination of sources – Child Surveillance Teams or Decision Support Teams of the Primary Care Trusts; coroners; the police; children's social care; public health; hospital records departments; and registrars. An issue was notification of deaths of children living in an area but who die outside, for example, if they are at school in one area but live in another. There were problems accessing information from regional hospitals. Geographical boundaries could cause problems in terms of workload, for example, one LSCB received notifications of all child deaths from a tertiary hospital in their area regardless of the child's place of residence. These concerns could be a significant problem since evidence suggests that 40% of deaths of children under one and between a quarter and a third of deaths of older children occur outside the area in which the child resided, making local ascertainment of death problematic (Ward Platt 2007).

Participants in the Sidebotham et al (2008) study cited various systems for review of children's deaths - local case discussions for SUDI; local case discussions for other unexpected child deaths; infant mortality reviews in hospital and by the perinatal unit; other hospital mortality reviews and domestic violence reviews; but there was not a consistent process. The nine sites all had

protocols for responding to unexpected childhood deaths, many of which had been operational for several years, but most covered only unexpected deaths of children under two. There were some concerns about reviewing all deaths from 0 to 18 (excluding stillbirths), particularly in relation to the neonatal period and later adolescent period, since different professionals are involved with the older age group than the younger. In many sites there was already some sort of hospital based neonatal mortality review and the challenge was to try to include them in the CDOP process rather than replace a well functioning system. Some teams were dividing deaths into categories and reviewing all deaths within one category at a time to enable appropriate expertise to be brought in to support the panel. There was a general sense of enthusiasm for developing child death review processes but there was some frustration at the perceived lack of central guidance other than that set out in Working Together. Working Together (HM Government 2006) requires LSCBs to establish CDOPs for populations greater than 500,000 and stated that neighbouring authorities LSCBs could form combined CDOPs to achieve this population size. Sidebotham et al (2008) found that some panels were planning to develop a combined CDOP but others were not keen to do so even where population numbers were low. They concluded that teams could function with smaller and larger populations and should consider what configuration best meets their needs. Ward Platt (2007) states, however, that from his experience in the North of England (a participating region in the CEMACH child death project), it makes sense for adjacent LSCBs to pool expertise and cover larger populations than their own. He suggests between 500,000 and a million seems about right as it allows a reasonable number of deaths to be scrutinised each year without the process becoming too burdensome.

All teams who participated in the Sidebotham et al (2008) study were opting for a core membership with additional co-opted or ad hoc membership. Those professionals most commonly named for core membership included public health, coroners, children's social care, police and paediatricians; ad hoc or co-opted membership included education, drug and alcohol teams, CAMHS and adult

mental health. Teams were uncertain whether to include some professions as core or ad hoc members, for example, education, the coroner or midwifery. Involvement of some core members, particularly public health and coroners was difficult to ensure, and Sidebotham et al pointed out that there may be particular difficulties for agencies that cross boundaries such as the police. Membership tended to come from existing LSCB groups. At most sites members were relatively senior and experienced. The issue of independence was viewed as important: some study participants suggested representatives from neighbouring trusts would be useful; others suggested having lay representatives on the panel. The chair was seen as a generic role which could be filled by anyone with good chairing skills rather than needing to come from a specific discipline but it was viewed as important that the chair should be independent of direct decision making involvement in any of the cases or direct line management responsibility of front line practitioners.

Working Together (HM Government 2006) includes a diagram to explain the interface between child death and SCR but Sidebotham et al (2008) found there were issues around linkage of the two processes. There was a clear message that SCRs were intensive, demanding and time consuming and that child death review processes could not and should not go into the same kind of depth. Interviewees were also unclear about the distinction between child death overview processes and rapid response processes. They talked about the differences between the multi agency child death overview and other hospital based mortality reviews which were already being undertaken in many places and generally considered that the CDOP should consider cases only after the conclusion of any rapid response process, criminal investigation or SCR.

Sidebotham et al (2008) found that so much time had been spent on setting up the processes that panels were only just beginning to think about systems for analysing information and acting on the findings of the analysis. Systems of audit and governance were not well developed but their importance was recognised. Few chairs had considered the implications of data storage and were vague

about the systems in place and it was not clear how they were dealing with issues around information sharing, confidentiality and data protection. None of the sites had yet involved parents in the review process but considered this to be an important area of development.

Drawing on the findings of the Sidebotham et al (2008) study as well as those from the CEMACH child death review study (Pearson 2008) the Department for Children, Schools and Families is developing a range of resources to support LSCBs – templates for national use in child death information collection, a system for national collation of data collected through CDOPs, and a range of training materials. The University of Warwick have launched a new national training resource that provides LSCBs with the materials needed to run local training courses for staff involved in child death reviews or in responding to unexpected childhood deaths.

Wales

LSCBs in Wales were not given responsibilities to review all child deaths from 0 to 18 or to respond rapidly to individual unexpected deaths of all children in the local area as LSCBs in England were under the Children Act 2004. Because the population base of LSCBs in Wales is significantly less than the recommended 500,000 for child death review arrangements in England the Welsh Assembly Government has been investigating whether an All Wales approach for administering Child Death Reviews in Wales would be more feasible. The Welsh Assembly Government's Safeguarding Group has proposed arrangements for the setting up and running of a pilot study, to inform the development of child death reviews in Wales, including the creation of a national child deaths' database; completion of the CEMACH Data Collection Form for all child deaths; the process to select cases from the dataset held on the Child Death Database; the completion of the CEMACH Child Death Review Proforma by the Child Death Review Team from the information provided and the ability of the team to draw conclusions; and the ability of the National Public Health Service (NPHS) to act as a host organisation for the Child Death Review Team. The pilot will begin in Autumn 2008 and will run for 18 months with the aim of introducing a full Child Death

Scheme from 1 April 2010.

Wales also has a national protocol for dealing with SUDI (National Public Health Service for Wales 2006) which sets out how all agencies must work together when dealing with deaths of children up to the age of two but the protocol is locally managed, there is not a consistent reporting process across Wales. In some parts of Wales the protocol is used for unexpected deaths of all children up to the age of 18.

Northern Ireland

A case management review report following the death of David Briggs, a twin adopted in Romania, in 2003, recommended a multi agency approach be used in all cases of sudden unexpected child death in Northern Ireland. The Lewis report, commissioned by the then Minister for health, social services and public safety after the Briggs case, endorsed this recommendation. In December 2006 the Department of Health, Social Services and Public Safety (DHSSPS) carried out a consultation exercise into procedural guidelines in cases of sudden unexpected child deaths. The Regional Child Death Review Protocol (the regional protocol) recommends a multi agency approach. It outlines the responsibilities of statutory agencies and professional staff when dealing with the sudden or unexpected death of any child from birth to 18 whether that death occurs at home, in a community setting or in hospital. It requires that at a very early stage after the child's death the professionals who have been involved with the child meet and share information about the child, including details about the death and other circumstances. The draft regional protocol takes account of best practice and recommended procedures arising from the most recent developments in policy and research within this area of expertise.

The DHSSPS has recognised that there is a need for analysis of the information arising from sudden or unexpected child deaths but it has yet to be decided who will do this because it is likely to be too big a task for the new Safeguarding Board for Northern Ireland.

New processes for wider review of child deaths: summary

- Since 1st April 2008 LSCBs in England have had a duty to review all deaths from 0 to 18 in a systematic way through a Child Death Overview Panel (CDOP); to respond rapidly to individual unexpected deaths of all children through a Rapid Response Team (RRT); and to use the aggregated findings from all deaths to inform local strategic planning on how best to safeguard and promote the welfare of children in their area
- LSCBs in Wales were not given responsibilities to review all child deaths or respond rapidly to unexpected deaths of all children; Welsh Assembly government is, however, running a pilot study to investigate whether an All Wales approach for administering child death reviews would be more feasible
- In Northern Ireland a draft Regional Child Death Review Protocol has been developed for dealing with all unexpected deaths of child aged 0 to 18
- Processes for wider review of child deaths have not been introduced or proposed in Scotland.

Child death and serious case review processes: effectiveness and learning

Background

This section of the paper looks at the effectiveness of child death and serious case review processes. It looks firstly at the extent to which processes for reviewing child deaths from abuse and neglect have been an effective learning tool in the UK. It then looks at the effectiveness of processes for wider review of child deaths. Evidence of the effectiveness of processes for wider review of child deaths comes mainly from the US where child death review processes have been in existence for much longer than in the UK.

Serious case review processes

The case review processes in different parts of the UK have the same purpose - to establish whether lessons can be learned from a case in terms of improving inter agency working and better protecting children. They are intended to be used as a learning tool, not as a means of attributing blame. The introduction of SCR processes by ACPCs in England and Wales was

a deliberate move away from the type of large scale inquisitorial style inquiries which characterised the 1980s. There have been attempts to learn from SCRs at national as well as local level through collation of findings across areas. In the 1990s three studies collated material from SCRs in England (Falkov 1996, Reder et al 1993 and Reder and Duncan 1999). More recently to try and bring clear standards and more consistent approaches to the case review process there has been a move to collate the findings of such reviews in England through biennial analyses designed to draw out key findings and assess their implications for policy and practice locally and nationally. The first of these biennial reviews by Sinclair and Bullock was published in 2002; two further reviews by Rose and Barnes and Brandon et al were published in 2008. In addition the Secretary of State for Children, Schools and Families announced in October 2008 that the government would carry out a study to examine the processes of commissioning, conducting and implementing SCRs which will report in summer 2009.

In Wales studies of SCRs have also been commissioned to inform policy (e.g. Brandon et al 1999; Brandon et al 2002; Morris et al 2007). Safeguarding Children: Working together under the Children Act 2004 (Welsh Assembly Government 2006) states that depending upon the number of reports received, the Welsh Assembly will commission overview reports every two years to draw out key findings and consider their implications for policy and practice.

In Scotland CPCs have been asked to produce a summary of cases sent to them over the course of the year and introduce these into the learning cycle, whether the decision was to undertake a significant case review or not (Scottish Executive 2007). CPCs have also been asked to send summaries of cases to the government as some recommendations for reviews may be for consideration at national level. Interim Guidance for Child Protection Committees (CPCs) for Conducting a Significant Case Review (Scottish Executive 2007) also states that the government will circulate reports to inspectorates and communicate with organisations such as universities and colleges, NHS Education, and

regulatory bodies such as the Scottish Social Services Council if recommendations from reviews have implications for them. However, no analysis of the findings from Significant Case Reviews across Scotland has been undertaken.

In Northern Ireland ACPCs have to provide a copy of the review report to the Department of Health, Social Services and Public Safety which is responsible for identifying and disseminating common themes and trends which emerge across ACPCs' review reports. Co-operating to Protect Children (Department of Health, Social Services and Public Safety 2003) states that the Department will commission regional case management overview reports which will be published at intervals to maximise learning. Researchers from Queens University and the NSPCC have been commissioned by DHSSPS to evaluate the operation of the case management review process in Northern Ireland.

Axford and Bullock (2005) commented in their study of international approaches to significant case review that there is very little material about the effectiveness of SCRs. As a result the second biennial study in England focused on exploration of the factors influencing the case review process and the impact of the findings on local policy and practice. Rose and Barnes (2008) found that SCRs were generally regarded as a valuable and important response to child deaths or serious injuries. The commitment by the government to national studies of SCRs and their wide dissemination was valued but there were some compelling debates about whether SCRs are the best, or only, vehicle for generating lessons to be learned.

The third biennial analysis report (Brandon et al 2008) comments that the extent to which SCRs are available publicly compromises the national learning that can come from them. Of 161 reviews which were included in the analysis 17 executive summaries were available on LSCB/ACPC websites making them fully accessible; the availability of the others was restricted. Brandon et al pointed out, however, that there are issues of confidentiality for the family and staff involved if LSCBs make the reports available to the public. Another issue they identified was that if summaries are very

bland, or focus exclusively on recommendations and procedures, then learning will be limited. There was wide variation in the way executive summaries were written in terms of length, structure and detail and Brandon et al recommended greater consistency in format and structure. They also suggested that if SCRs are analysed every two years there is a need for consistently reported minimum information to provide a better understanding of the total cohort.

The Ofsted evaluation of SCRs (Ofsted 2008) provides some evidence of the effectiveness of SCRs. A large proportion of the case reviews evaluated by Ofsted (20 out of 50) were judged to be inadequate, largely due to the time it took to complete them and the poor quality of individual management reviews. Ofsted concluded that SCRs were effective at identifying what happened to the children concerned but were less effective at addressing why. A common failing was to focus recommendations on policies and procedures rather than on practice and what needs to change.

Rose and Barnes (2008) point out that it is important to bear in mind that SCRs are only one source of evidence about what is happening in work to safeguard children. Child deaths are comparatively rare, yet they have had an inordinate and inappropriate level of influence on safeguarding policy.

'Understanding what went wrong is a limited activity to which only modest resources should be committed' (Masson 2006).

The fact that SCRs have regularly identified the same problems in front line practice and made similar recommendations has raised questions about their effectiveness as a learning tool for improving practice. The Social Care Institute for Excellence (SCIE) have responded to these questions by developing an alternative approach to case review (Fish et al 2008). They have produced a resource for undertaking a multi agency systems approach for organisational learning across agencies involved in safeguarding children. The approach, which is widely used in engineering, health and other high risk industries, provides the opportunity to study the whole system so

that we can learn from what is working effectively as well as from what is not working well. The model can be used in SCRs, in the collation of findings from multiple case reviews at local, regional and national level, and in reviews of routine work. Rose and Barnes (2008) have similarly argued that approaches which enable us to learn from effective safeguarding practice, rather than mistakes, would be a far better way to proceed.

Wider child death review processes

Onwuachi-Saunders et al (1999) have argued that SCRs provide useful information about child abuse and neglect deaths but:

'The challenge is to expand child death reviews beyond the focus of child abuse and neglect to one of public health so as to identify preventable child deaths and achieve effective prevention' (278).

New child death review processes in England are an attempt to do this. The CEMACH study report (Pearson 2008) points out that half of the deaths which panels considered might have been avoided would not have been identified as 'unexpected' under the Working Together definition. This highlights the need to review all child deaths.

There is a growing body of evidence on the effectiveness of child death review processes in other countries although much of it relates to activity stemming from the process rather than specific outcomes for children. Bunting and Reid (2005) identified a number of benefits including improved multi agency working and communication; more effective identification of suspicious cases and a decrease in inadequate death certificates; a more complete and accountable process and a more in depth understanding of the causes of child death from a narrow and stigmatising focus on child abuse towards a public health model which focuses on the prevention of all deaths.

In the US and Australia comprehensive child death review programmes have contributed significantly to knowledge about child abuse and neglect. Knowledge from child death review has led to policies and initiatives which

have made major contributions to keeping children safe such as the fencing of domestic pools and the use of child cycle helmets. In Arizona the Child Death Review Team supported increased enforcement and community education regarding Arizona's child safety restraint laws, including legislation establishing a graduated driver's licence programme for teens (Rimsza et al 2002). In Philadelphia as a result of information from child death reviews school nurses have received training in domestic abuse, there has been enforcement of child safety seat law, recognition of the need for Fire Starter programmes for children aged three to seven and recognition of the need for non battery powered smoke detectors (Onwuachi-Saunders et al 1999). Evidence from child death reviews can also be used to identify special population groups that need targeted prevention programmes. For example, the Arizona Child Death Review Team found that unintentional injury deaths and suicide were more common in native American communities, whereas deaths attributable to gunshot wounds occurred more frequently in Hispanic communities (Rimsza et al 2002).

Child death review teams in the US have, however, faced a number of difficulties. One of the main challenges has been the difficulty of obtaining and sustaining adequate resources and many teams have reported an inability to expand their focus or put prevention programmes into place (Durfee et al 2002). Lack of national leadership and coordination has meant there is wide variation in child death review team organisation and processes across the US and there are no national criteria by which programme structure and impact might be judged (Webster et al 2003). There are no standardised methods of data collection across teams so comparability of child deaths between states and the identification of national trends is impossible (Bunting and Reid 2005).

The Sidebotham pilot study (2008) provides some evidence of how new child death review processes in England are operating. CDOPs were at an early stage of development in the study but a number of outcomes were already being observed such as public awareness campaigns, community safety initiatives,

training of professionals, development of protocols and lobbying of politicians. Further evidence of the effectiveness of child death review in the UK comes from the CEMACH child death review study (Pearson 2008). The CEMACH study was a pilot study to determine whether confidential enquiry methodology could be used to identify avoidable factors in child deaths. It concluded that confidential enquiry methodology could be effectively used to determine whether the deaths of children could have been avoided. Interestingly the study included two consultation sessions with 24 young people aged 14 to 20. After reviewing three child death cases the young people felt they needed a greater awareness of danger in their lives, particularly with regard to substance misuse and traffic accidents.

The CEMACH study report (Pearson 2008) states that the findings of the study:

'indicate that the best approach to achieving these improvements is a public health model which combines the social, environmental and medical approaches to examine childhood deaths from multiple disciplinary and professional angles' (53).

It argues that a multidisciplinary approach provides the best opportunity to examine the major environmental influences on the child immediately prior to death and to ultimately identify why the child died, as well as providing the most professional approach for offering continuing support and explanation to the family. However, the report points out that enquiry is costly, time consuming and resource dependent and unlikely to be sustainable and generalisable without identified funding and:

'In order to justify these costs, the conclusions and recommendations must have the potential to improve the care given to children by professionals and carers and lead to avoidance of some childhood deaths' (13).

The report also states that:

'It is important for panels to remind themselves of their role, which is not to investigate the death in a tribunal style

setting but to identify risk to children and to use the findings to recommend solutions and best practice to reduce areas of critical risk to children' (94).

It argues that there needs to be consistency and standardisation across LSCBs and aggregation at a regional and national level if major issues and trends in child mortality are to be identified. It also points out that enquiry staff who were involved in the CEMACH study found the emotional content of their work demanding and stressful at times. This is likely to apply to staff involved in reviews in LSCBs as well and the report states that it will be important to ensure they are appropriately supported. Accountability is a further issue which the report suggests requires further clarification. It asks to whom CDOP decisions on contributory factors are accountable and who is responsible if recommendations for prevention are made but not carried through (if for example, children continue to die from preventable road accidents)?

The report concludes that overview of child deaths should be undertaken with four key outcome areas in mind:

- Improving understanding of patterns of childhood death;
- Improving the response to childhood death;
- Improved recognition of neglect and abuse leading to childhood death; and
- Improved interagency work to prevent childhood death.

Child death and serious case review processes: effectiveness and learning: summary

- Biennial reviews of the findings from SCRs are undertaken in England; in addition a study to examine the SCR process will report in 2009
- Reviews of the findings of SCRs are regularly undertaken in Wales
- No national analysis of the findings from Significant Case Reviews has been undertaken in Scotland
- An evaluation of the case management review process is being undertaken in Northern Ireland
- There is a growing body of evidence on the effectiveness of wider child death review

processes in other countries; benefits include a more in depth understanding of the causes of child death and the introduction of policies and initiatives which have made major contributions to keeping children safe

- The Sidebotham pilot study (2008) and CEMACH study (Pearson 2008) provide some evidence of the effectiveness of new child death review processes in England.

Conclusion

This paper has outlined the various processes which exist across the UK for reviewing child deaths and serious cases. It compared and contrasted the different approaches across the UK for reviewing deaths from child abuse and neglect. It also considered new processes for wider review of all child deaths, or all unexpected child deaths, which have been introduced or proposed across the UK. It considered only multi agency processes for reviewing child deaths; it did not look at predominantly health based approaches to reviewing child deaths. The paper found that all parts of the UK have similar processes in place to review deaths from child abuse or neglect. England and Wales have had processes in place since 1991 but Northern Ireland and Scotland have only introduced processes in the last few years. Although some countries have had processes in place to review all child deaths for many years England is the only area of the UK to have recently introduced processes for reviewing all child deaths. There are proposals to introduce new processes for wider review of child deaths in Wales and Northern Ireland but to date there are no proposals in Scotland.

Processes for review of deaths from child abuse and neglect were intended as a learning tool. In most parts of the UK attempts have been made to aggregate the findings from case reviews so that there can be national as well as local learning from such cases. The fact that SCRs regularly make the same recommendations has, however, raised questions about their effectiveness as a learning tool and both Northern Ireland and England are now undertaking reviews of the entire process of case review. Evidence from other countries suggests that wider review of all

child deaths might be more effective as a learning tool in terms of enabling identification of the causes of child death and leading to the introduction of policies and initiatives to prevent some deaths. Where such processes are being introduced in the UK processes for review of deaths from child abuse and neglect as well as other health processes for review of child deaths exist alongside and there is a need to ensure that these various processes fit together.

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